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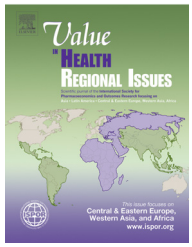

The Process of Privatization of Health Care Provision in Poland

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ABSTRACT

Objectives: In January 1999, a new institutional structure for Poland's health care system was laid out, instigated by the dramatic change in both the political and economic system. Following the dissolution of state socialism, private financing of health care services was encouraged to fill an important role in meeting rising consumer demand and to encourage a more efficient use of resources through competition and private initiative. However, from the outset of the intended transformations, systemic limitations to the privatization process hindered progression, resulting in varying rates of privatization amongst the distinct health care sectors. The aim of this paper is to describe the privatization process and to analyze its pace and differences in strategic approach in all major health care sectors. **Methods:** Policy analysis of legislation, government directives, and published national and international scientific literature on Polish health reforms between 1999 and 2012 was conducted. **Results:** The analysis demonstrates a clear disparity in privatization rates in different sectors. The pharmaceutical industry is fully privatized in 2012, and the ambulatory and dental sectors both systematically increased their private market shares to around 70% of all services provided. However, despite a steady increase in the number of private hospitals in Poland since 1999, their overall role in the health care system is comparatively limited. **Conclusions:** Unclear legal regulations have resulted in a gray area between public and private health care, where informal payments impede the intended function of the system. If left unchanged, official health care in Poland is likely to become an increasingly residual service for the worst-off population segments that are unable to afford the legal private sector or the informal payments which guarantee a higher quality service in the public sector.

Keywords: health care provision, health care reform, health policy, Poland, privatization.

Introduction

On January 1, 1999, a new institutional structure for Poland's health care system was founded, instigated by a dramatic change in both the political system and the economic system [1]. In the years preceding such change, a state-funded and centralized health care system had operated where the public sector had dominated in terms of both funding and service provision. The collapse of state socialism in 1989 because of increased opposition and a failing economy, however, had severe consequences on the state's ability to provide health care coverage [2]. This resulted in a growing imbalance between the needs expressed by the population and the system's ability to meet them, exacerbated by the ever-increasing cost of health care service provision. In an attempt to address this, Poland transformed the health care system and encouraged competition and private initiative [3,4]. From the outset of the intended transformations, however, systemic limitations to the privatization process have hindered progression. This has resulted in varying rates of privatization among the distinct health care sectors and an ambiguous relationship between public and private health care provision.

Initial Drivers for Health Care Reform

During state socialism, Poland, like many other Soviet bloc nations, adopted the Semashko model for health care [5]. State-funded through taxation and heavily centralized, this particular system was designed with the intention of guaranteeing egalitarian health care coverage for the entire population. After the dissolution of the Soviet Union, however, Poland along with many other Central European countries suffered severe economic difficulties that significantly affected health care provision [6]. Because of cuts in government expenditure and a shortage of providers, public health care facilities became overcrowded and had long waiting lists, scarce medical supplies, and out-of-date technologies [7]. Receptive to this, Poland began to allow limited private providers to manage demand for public health services [8]. The principal idea envisaged was to establish a new set of institutions and market-type mechanisms that would ensure a more efficient use of productive assets by creating stronger incentives arising from ownership, thereby increasing productivity and efficiency [3,9,10]. This signaled an initial step toward privatization, defined as follows: "the transfer of ownership and

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control of government or state assets, firms and operations to private investors" [11].

After this, the public sector gradually began to devolve further until budgeting of health care services was replaced with an insurance-based system of financing. Undoubtedly, this radically changed the population's right to health services, as access was instantly linked to registration with a mandatory health insurance and payment of contributions [5]. As insurance funds were initially regional and given autonomy, conditions were set for private sector service provision, which then intensified as official out-of-pocket payments for health services were started [12]. Alongside hospitals, clinics, and health centers, foundations or voluntary associations were established, which accepted payments for performing better quality or difficult-to-access services. This divided health care provision into both public and private, with a gray sphere of informal payments emerging between the two [2] that continued a long-standing history of informal payments in the socialist health system.

In the 2007 Stefan Batory Foundation's Corruption Barometer, 78 (9%) of 870 respondents declared that they had made informal payments in the last year, 52% of which were for informal payments in health care [13].

In the larger Social Diagnosis panel of 3000 Polish households, 1.8% of households declared informal payments in 2007, 1.3% in 2009, and 1.7% in 2011 [14]. In 2011, the average informal payment for health services was estimated at 1244 Polish Zloty (300 euros) per year and household. Furthermore, 18.1% of households declared that they refrained from purchasing necessary medicines, 17.3% could not afford dental treatment, and 13.9% could not afford medical treatment [14].

Legal Basis for Privatization

Between 1989 and 2001, approximately 20 new laws relating to health care provision were adopted in Poland, which facilitated the development of the private sector. In particular, the law of July 13, 1990, which related to the privatization of state enterprises [15], and after its abolition the law of August 30, 1996, which related to the commercialization and privatization of state enterprises [16], were exceptionally influential in instigating the privatization process. Although these acts did not directly refer to health care services, they drew a general framework for the process of privatization in Poland after the fall of communism.

The most important and far-reaching legislative acts to affect health care were those that shaped the contracting environment. The Health Care Organisation Act passed in 1991 introduced contracting in place of administrative relationships, allowing private surgeries and organizations to sign contracts for the provision of services to people entitled to care financed from public resources [17]. In doing so, categories of entities authorized to provide health services (including those that are established by nonpublic entities or individuals) were defined, as well as the technical requirements that such entities must fulfill.

This was followed by perhaps the most influential act—The General Health Insurance Act 1999, which introduced a social health insurance system in Poland of 16 regional sickness funds and 1 sickness fund for employees of military services [18]. This caused a vast increase in the number of private organizations holding public contracts because the regional sickness funds were allowed to contract services with private health care institutions as long as they met the required conditions and offered cheaper service costs [8]. This was the first time private providers were able to act within the public system of financing health services.

In addition to these, a package of laws regulating the competences of local self-government units have since been passed, which have gradually transferred the ownership duties of health care facilities from the central administration units to the local self-governments, enabling them at the same time (under some conditions) to transform those facilities into private entities. These laws include

- the law of March 8, 1990, on local self-government [19];
- the law of November 24, 1995, on a change in the range of responsibilities of some cities on the municipal areas of public services [20];
- the law of June 5, 1998, on regional self-government [21]; and
- the law of June 5, 1998, on district self-government [22].

None of these legal acts, however, has directly and systematically regulated the issue of privatization of health care facilities. This has resulted in a process that is complicated, legally unclear, and vulnerable to abuses, particularly in the case of hospitals that are the most controversial in terms of their privatization. During the last decade, successive governments have tried on three occasions to establish such a law but none of these efforts has been successful, each time being blocked during the legislative process, or even earlier, at the stage of preparation. In its first attempt, the Ministry of Health tried to implement obligatory transformation of all health care organizations into commercial law companies, entitled "Law on Commercialisation and Privatisation of Independent Public Health Care Facilities (2001)." Nevertheless, because of unfavorable political conditions (forthcoming elections, a breakdown of the governing coalition, and a strong political disintegration), the project was withdrawn and replaced with a less radical approach.

Progress of Privatization in Poland

An analysis of the scale of privatization in the Polish health care system shows significant disparity between the different health care sectors. Changes in the pharmaceutical sector and in ambulatory, dental, and hospital care differ in terms of pace, strategic approach, and public resistance. To understand these fundamental differences, each sector will be discussed separately.

Pharmaceutical sector.

The commercialization of health services began with the privatization of the pharmaceutical industry. This was based on the Freedom of Economic Activity Act (1988), which came into fruition at the very beginning of the postcommunist transformation period [23]. Around the same time, the number of private pharmacies accounted for approximately 43.9% of the total number. Following a program implemented in 1994 devoted to the privatization of pharmacies, however, almost all pharmaceutical outlets belonging to the Treasury have subsequently been privatized [24]. This dynamic transformation in pharmacy ownership between 1990 and 2006 is illustrated in Fig. 1.

Since the introduction of co-payments for dental care, patients have started to purchase services offered by private practices and clinics more willingly, even when required to cover the total cost of the treatment. In doing so, they are able to receive a faster and perceived better quality treatment. Because of this high acceptability, the private dental sector developed quickly in the early 1990s. After the Law on Social Health Insurance came into force in 1999, private dental practices started to offer treatment contracted within the Social Health Insurance system. As a result, the number of facilities offering services that are available only for out-of-pocket payments has started to decrease gradually since 1999 [25]. Currently, more than 80% of the active dentists work in the private sector and approximately 85% of the services are provided by nonpublic providers [26].

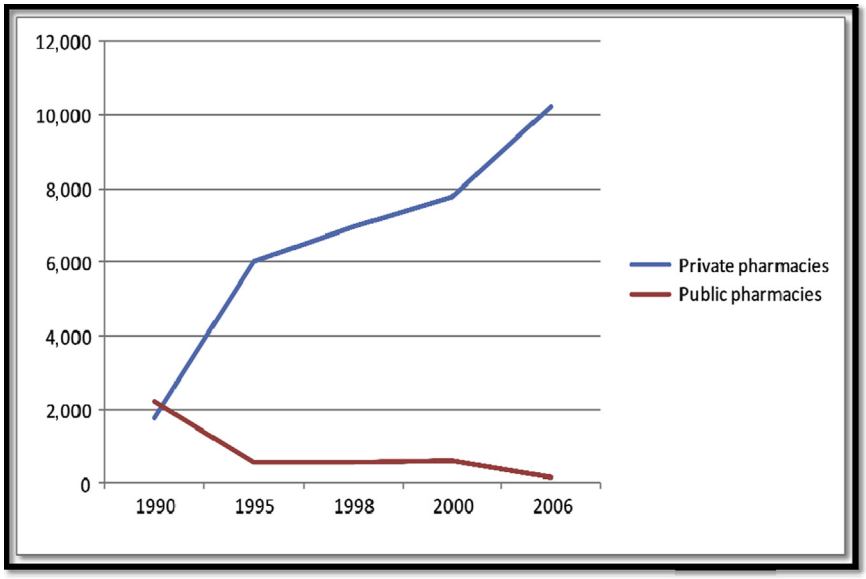


Fig. 1 – Dynamics changes in pharmacy ownership between 1990 and 2006.

Ambulatory care.

Until 1990, hospitals were responsible for the delivery of specialist outpatient services as well as for laboratory and imaging diagnostics. The separation of hospitals and ambulatory care was the first step toward the transformation of service provision. This subsequently offered a great opportunity to invest in the ambulatory care infrastructure when previously inpatient services that are in general more expensive than outpatient services had received financial priority.

In the mid-1990s, the process of privatization was directed toward outpatient care. In the first phase of the process, nonpublic facilities were established mainly by individuals (doctors, nurses, and other medical practitioners) and companies, who became responsible and accountable for providing health care services [27]. Later, the local self-government units joined the process by transforming the facilities they owned when the package of laws reforming the system of public administration came into force. These were, however, based on legal regulations that enabled only large cities to do so in 1995 and all other local government units from 1999 onward. This coincided, however, with the introduction of the Social Health Insurance Law in 1999, which enabled nonpublic health care providers to enter into contracts with public insurers [28]. This allowed self-government units to privatize their ambulatory care facilities in two distinct ways:

1. The first involves holistic transformation of the public entity through its liquidation. In this case, the duty to provide services is transferred to a private entity together with ownership of the technical infrastructure. Formally, the unit that opts for such a procedure must adopt a resolution to liquidate the facility as well as to define the procedure of its transfer to the nonpublic entity [29].
2. The second method involves separation of the service provision from the structures of the facility and a transfer of the provision function to a private entity. Contrary to the first method, in this case the self-government unit does not liquidate the facility but adopts a resolution on its restructuration. Formally, the infrastructure ownership remains public [28].

In view of the above-mentioned legal changes, ambulatory care privatization has been accelerated since the mid-1990s. This is illustrated in Fig. 2, which highlights the increase in the number of private ambulatory care providers since 1990.

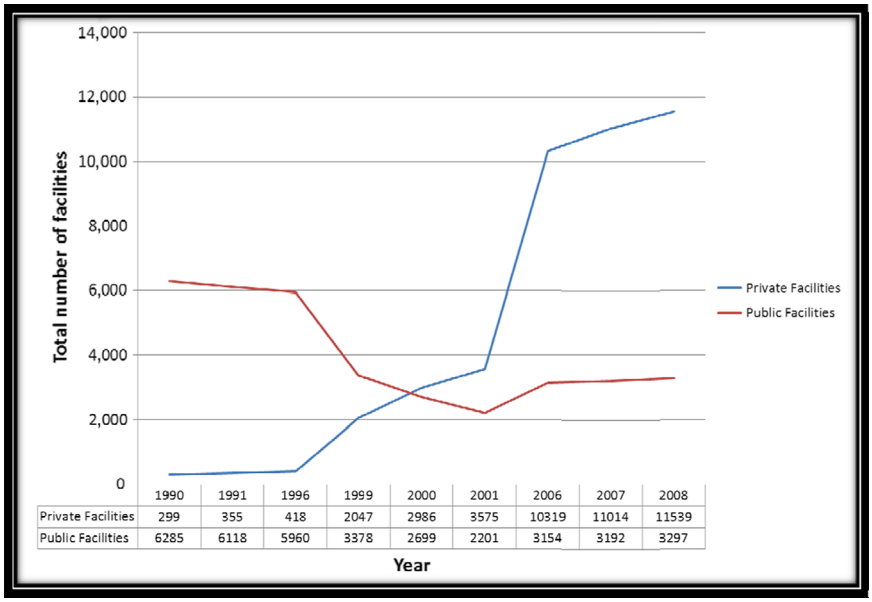
As stated previously, the past two decades have seen an immense increase in the number of private ambulatory care facilities in Poland. In 1990, 4.5% of the ambulatory care facilities were privately operated; by 2008 this had increased to 77.8% [26]. The increase in privately owned facilities was particularly fast during the period between 1999 and 2002 before stabilizing to an approximate increase of 3% each year. During this time, public facilities decreased by approximately 47.5% [26].

Currently, the private sector is dominating outpatient care, which is illustrated by the number of services provided. In 2008, a total of 290,553,000 services were provided; of these, 202,785,000 were provided by private facilities, meaning that services provided by public facilities account for only 30% of all services provided [30].

Hospital care.

The postwar history of private hospitals in Poland is relatively linear. Those that resumed activity after 1945 were closed a few years later because the government continued to transform both the economic and the health system into the Semashko model. The networks of private providers, however, started to reestablish themselves after the fall of communism in the 1990s. The first private hospitals were established between 1993 and 1994 and began their operations as single departments established mostly alongside outpatient health centers, and only later developed further more advanced services. The process of the development of the private sector in inpatient care is much slower than in the other sectors previously described. The main reason behind this largely relates to the extent of the higher financial risk and investment required, and the widespread existence of political beliefs opposing hospital privatization.

Perhaps most significantly, there is often a public and political unwillingness toward hospital privatization that is of particular concern for postcommunist countries. During the communist period, health care was generally considered to be a “social service” that should not be determined by economic measures of efficiency



	1990	1991	1996	1999	2000	2001	2006	2007	2008
Private Facilities	299	355	418	2047	2986	3575	10319	11014	11539
Public Facilities	6285	6118	5960	3378	2699	2201	3154	3192	3297

Fig. 2 – Structure of the ownership of ambulatory care facilities in Poland (1990–2008).

[31]. Consequently, strong public opposition remains one of the key barriers to the privatization of health care, driven by beliefs that

- hospital services are of a specific nature and they should not be subject to a profit motive;
- private hospitals are acting mainly for the profit of their owners, which is in conflict with the mission of health care facilities;
- privatization of hospitals equals charging patients for the services; and
- nonpublic hospitals are unwilling to provide highly complex medical procedures because of their unprofitability, which may cause a limitation of access to such services.

Furthermore, the lack of a comprehensive legal basis for privatization constitutes an obstacle for the development of this sector. Despite these limitations, the process is still progressing, largely through the local self-governments, for which the transformation of hospital facilities they own is becoming increasingly popular [32].

Since 1999, self-government units have transformed 130 hospital units into commercial companies; this includes 77 hospitals and 53 single hospital departments [33]. In many cases, the situation is becoming paradoxical because self-government units still remain formal owners of the privatized hospitals, which makes them so-called nonpublic self-government-owned hospitals. The difference between such an organization and a traditional one is that these hospitals are acting as companies under commercial law and not as the "independent public health care facilities" as it was before they were restructured. Table 1 summarizes the dynamics of the development of the nonpublic hospital sector in Poland over the past two decades.

Of the 120 nonpublic hospitals currently operating in Poland, 77 are those that have been restructured by local self-government units. This constitutes 64.2% of the number of private hospitals and 10.4% of the total number of private hospitals in Poland [26]. In recent years, the general share of private hospitals equates to approximately 20% of the total, and when taking the number of beds into consideration, it is less than 6%. In 2007, nonpublic hospitals signed contracts with the social health insurance funds for an amount of more than 600 million Polish Zloty (145 million euros), which equates to approximately 3.2% of the total public resources spent on hospital care [26].

Cost-Effectiveness of Privatization

Because of issues regarding the availability of data, a comparison of the cost-effectiveness of public and private health care poses a significant problem. Private entities generally do not release relevant information, and available sources are generally limited

Table 1 – Structure of ownership of hospital care facilities in Poland (1999–2007).

	1999	2000	2001	2002	2003	2004	2005	2006	2007
No. of private hospitals	21	30	45	61	72	147	170	153	170
No. of beds	446	1,574	2,476	4,221	5,171	7,649	8,215	9,318	10,204
Total hospitals	715	716	736	739	732	790	781	742	748
Total beds	198,688	190,952	188,234	188,038	186,043	183,280	179,493	176,673	175,023
% of private hospitals	2.9	4.2	6.1	8.3	9.1	18.6	21.8	20.6	22.7
% of private beds	0.2	0.8	1.3	2.2	2.8	4.2	4.6	5.3	5.8

to the presentation of a few selected individuals. Existing data, however, suggest an average growth of within 20% to 30% in private sector revenues annually. The overall size of the sector was estimated at about 1915 million Polish Zloty (462 million euros). This information confirms an analysis by the National Association of Private Employer Health Care (2009), who conducted a study involving nine private companies providing medical services. The analysis indicated that in 2007 and 2008, the annual growth of the sector revenue amounted to 31.1% and 33.1%, respectively, and the value of income in 2008 was estimated to be 930.4 million Polish Zloty (225 million euros). On average, survey participants within the health profession indicated that their income in 2006 increased by approximately 32.9% in 2007 and 35.3% in 2008. In comparison with the public sector, employers' contributions to medical care for their employees were the dominant source of revenue for private providers. These accounted for nearly 44% of the revenue [34].

Quality of Care—Private versus Public

The private and public sectors in Poland also differ in terms of the perceived quality of care reflected in patients' opinions. Several opinion polls dedicated to this issue share the same conclusion—in general, private services are considered to be of a higher quality, with the most significant differences stated to be the physician's manner toward patients. In a survey conducted by the marketing research and opinion poll company Partner in Business Strategies in 2007 [35], respondents compared public and private services with respect to atmosphere, doctor's commitment, and respect to patient privacy. For these three criteria, private providers were considered significantly better than the public sector. With respect to atmosphere, 54% of the respondents declared that private providers are better, with only 10% declaring the opposite. Results for doctors' commitment and respect for patient's privacy were also in favor of the private sector (51% and 47% for private providers and 9% and 8% for public providers, respectively). The general quality of services was also recognized as being better in the private sector, and of all respondents, 45% declared the private sector as being superior, with only 10% having the opposite opinion. One of the few areas in which the study showed no significant advantage to the private sector was with respect to the experience of the doctors. Although 19% of the respondents thought that more experienced and better qualified doctors worked in private health care, 17% of the respondents considered the quality of doctors better in the public sector. It is worth noting at this point that almost two-thirds of the respondents had no opinion on this matter, which may suggest that differences in knowledge and experience are difficult to judge for patients.

Conclusions

A free health care market does not exist in Poland, nor is it planned to be one. Since the dissolution of state socialism, private financing of health care services has increased substantially and has filled an important role in meeting the increasing consumer demand in some areas of health care and, to some extent, encouraging a more efficient use of scarce resources through competition and private initiative for public health services. This step toward privatization is mostly evident within the pharmaceutical industry, which is now fully privatized. In addition, the ambulatory sector has systematically increased its private market share to approximately 70% of all services provided and is continually moving toward full privatization. Despite the regular increase in the number of private hospitals in Poland, however, their role in the health care system remains comparatively limited. This is largely due to complicated and unclear legal regulations, resulting in a gray area between public and private health care where informal payments impede the intended function of the system. If this is left unchanged, the official public health care sector in Poland is likely to become an increasingly residual service for the worst-off patients, who are unable to afford the legal private sector or the informal payments that guarantee a higher quality service in the public sector.

Of prime importance, however, as with many postcommunist countries, one of the key barriers to health care privatization is the traditional belief that health care should be a "public service," not determined by economic measures of efficiency. With the heritage of the communist period hard to overcome, strong public opposition will remain one of the key barriers to the privatization of health care.

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